EpiNotes
Disease Prevention and Epidemiology Newsletter
South Carolina Department of Health and Environmental Control

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Changes in the SC 2006 List of Reportable Conditions

Libby C. Greene, MSN, APRN, BC
Director - Surveillance Section/Nurse Consultant

As authorized by South Carolina Statute #44-20-10 and Regulation #61-20, the S.C. Department of Health and Environmental Control (DHEC) updates the list of Reportable Conditions in January of each year. Revisions to the list of reportable conditions are based on many factors, including: 1) the need for DHEC to conduct surveillance on new conditions or to increase surveillance on certain existing conditions in order to protect the health of the public and 2) changes in reporting requirements from the Centers for Disease Control and Prevention (CDC).

The following revisions have been made to the 2006 List of Reportable Conditions:

Deletions from the list:

- Vancomycin-resistant enterococcus (VRE)
- HTLV I and II

Additions to the list of conditions to report Within 7 Days:

- Yersiniosis (Lab only)

Revisions:

- "Encephalitis, arthropod-borne disease" listed in the "Urgently Reportable" conditions list has changed to: "Arboviral Neuroinvasive Disease (acute infection, including acute flaccid paralysis, atypical Guillain-Barré Syndrome): Eastern Equine Encephalitis (EEE), Lacrosse (LAC), St. Louis (SLE), West Nile Virus (WNV)"
- HIV quantification/viral load in the list of conditions to report within 7 Days: "all results" has been added

In addition to the above changes, "genotyping" has been added to the List of Reportable Conditions in footnote #7 located on the S.C. List of Reportable Diseases poster and on the web site. Also, due to reorganization of DHEC county

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Addition of Yersiniosis to 2006 List of Reportable Conditions

Marcia L. Headrick, DVM, MPH
State Public Health Veterinarian

Yersiniosis is caused by the gram-negative bacillus, *Yersinia enterocolitica*. The organism is most commonly found in pork products, but has also been found in contaminated raw milk, ice cream, tofu, and shellfish. It has also been identified in ponds, lakes, and streams contaminated by animal feces. Yersiniosis is a zoonotic disease, a disease that can be transmitted between animals and humans. It is usually transmitted to humans via consumption of food contaminated with animal feces, particularly swine feces.

Most cases of yersiniosis are not diagnosed, possibly due to mild symptoms or because the disease is not commonly suspected and laboratory testing is not routinely conducted. Unfortunately, small children and infants are most often affected and their symptoms can be severe, including bloody diarrhea, abdominal pain, and fever. Yersiniosis in older children and adults may mimic appendicitis. Joint pain has also been reported in infected adults.

In the U.S., human outbreaks of yersiniosis have been linked to the consumption of pork chitterlings (large intestines). The preparation of chitterlings, often called "chitlin's," includes cleaning of the large intestines with a small brush. During the cleaning process, there is significant potential for contamination of the cleaning area and cross-contamination of other foodstuffs. Cases of yersiniosis linked to consumption

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public health departments, please note on the Web site and on the poster that the public health departments are now listed by Regions rather than by Districts and that several of the addresses and phone numbers have changed.

The above changes may be found:

- In this edition of the Epi Notes
- On the DHEC Web site at: http://www.scdhec.gov/ health/disease/index.htm or http://www.scdhec.gov/health/disease/docs/reportable_conditions.pdf
- On the 2006 DHEC Disease Reporting Card (color is yellow for 2006)
- On the 2006 list of Reportable Conditions poster. Both the Disease Reporting Cards and the laminated posters (sizes 8 ½ by 11 and 12 x 24) are available from your health departments or from the DHEC Division of Acute Disease Epidemiology in Columbia.

Removal of Laboratory Reported HTLV-I and HTLV-II Infections from the 2006 South Carolina List of Reportable Conditions

Daniel Drociuk
Director - Response/Enhanced Surveillance Section

Human T-lymphotropic viruses types I (HTLV-I) and II (HTLV-II) were the first human retroviruses discovered.[1,2] They are only distantly related to the human immunodeficiency viruses (HIV-1 and HIV-2), which belong to the lentivirus subfamily of retroviruses and cause the acquired immunodeficiency syndrome (AIDS). Infections with HTLV-I and HTLV-II are most easily detected serologically, with the presence of antibodies to HTLV-I or HTLV-II indicating a person is infected with the virus. In industrialized countries HTLV-II is prevalent among drug abusers and is spread by contaminated needles and by heterosexual transmission.

Public health interventions associated with the reporting of HTLV-I or HTLV-II infection are limited. HTLV-I has been associated with adult T-cell leukemia/lymphoma (ATL) and a chronic degenerative neurologic disease, and HTLV-I-associated myelopathy/tropical spastic paraparesis (HAM/TSP). HTLV-II infection has not been clearly associated with any diseases with the virus first being isolated from two patients with hairy cell leukemia. No evidence of HTLV-II infection was found in 21 additional patients with hairy cell leukemia who were examined.[3]

To those ends, laboratory reporting in South Carolina of HTLV-I and HTLV-II infections are no longer required and have been removed from the 2006 List of Reportable Conditions.

However, since HTLV-II is known to be endemic among several Amerindian populations in North, Central and South America, the potential for follow-up and investigation of possible clusters exists[4] with serological and clinical information associated with possible cases required from providers to assist with the public health investigation.

References:

[1] Poiesz BJ, Ruscetti FW, Gazdar AF, Bunn PA, Minna JD, Gallo RC. Detection and isolation of type C retrovirus particles from fresh and cultured lymphocytes of a patient with cutaneous T-cell lymphoma. Proc Natl Acad Sci USA. 1980; 77:7415-9.

[2] Kalyanaraman VS, Sarngadharan MG, Robert-Guroff M, Miyoshi I, Golde D, Gallo RC. A new subtype of human T-cell leukemia virus (HTLV-II) associated with a T-cell variant of hairy cell leukemia. Science. 1982; 218:571-3.

[3] Centers for Disease Control and Prevention and the U.S.P.H.S. Working Group. Guidelines for Counseling Persons Infected with Human T-Lymphotropic Virus Type I (HTLV-I) and Type II (HTLV-II). Annals of Internal Medicine. 15 March 1993; 118:448-454.

4 Reported on October 7, 2005 by EINet of an HTLV-1 cluster in an Nunavut community. Accessed on November 25, 2005 at: http://depts.washington.edu/einet newsbrief63.html?article=923#923

(YERSINIOSIS cont'd from Page 1)

of chitterlings occur most often during the winter holiday season since this is a traditional holiday food, especially in rural areas of the Southeastern United States, including South Carolina.

Yersiniosis has not been a required reportable disease in S.C. in previous years. However, according to inpatient and outpatient ICD-9 diagnostic data from the S.C. Hospital Discharge Data Set, twelve cases of yersiniosis have been identified in S.C. since 2000. Due to the potential public health impact of outbreaks, yersiniosis will be added to the S.C. List of Reportable Conditions in 2006 for laboratory reporting only. This will facilitate recognition of cases and initiation of appropriate public health action such as education on safe food handling practices. Hospital laboratories should consider routinely culturing stool specimens submitted during the winter holiday season on cefsulodin-irgasan-novobiocin (CIN) agar, a medium selective for Yersinia. Positive results should be reported to DHEC within seven days. Stool specimens from suspect cases may be submitted to the DHEC Public Health Laboratory, if local laboratory testing is not available.

Additional information on yersiniosis is available from the CDC at the following Internet address: http://www.cdc.gov/ncidod/dbmd/diseaseinfo/yersinia_g.htm

Changes in Reporting Antibiotic Resistant Organisms

Dixie F. Roberts, MPH, RN
Director, Division of Acute Disease Epidemiology

Antibiotic resistance continues to be a significant public health problem. Surveillance for the various types of resistance is complex and requires significant public health and health care system resources. DHEC is participating in CDC programs and activities to establish an effective surveillance system and to select the organisms for which surveillance data is needed for public health action. Future Epi Notes articles will describe proposals for improving antibiotic resistant surveillance, while coping with limited resources.

The DHEC 2006 List of Reportable Conditions no longer requires individual case reporting on the DHEC Disease Report Cards for Vancomycin resistant enterococcus (VRE). However, outbreaks of VRE in a health care facility are still reportable to DHEC, as is any outbreak or unusual disease or cluster of cases.

Since 1994, DHEC has required reporting of individual cases of patients with VRE positive cultures. S.C. data (figures 1-3) are consistent with national data showing an increase in VRE infection and colonization, and possibly improved reporting. Colonization with VRE is long term and accounts for positive cultures in the absence of disease. The data was reviewed for duplicate reports and, over a two-year period of time, at six months intervals, approximately ten percent of the reports were duplicates.

Individual case based reporting to public health is not the best way to monitor this nosocomial problem. The most critical data for prevention and control of VRE is that collected, analyzed, interpreted, and disseminated by each health care facility (e.g. hospital, long term care, dialysis centers). This facility-based data will allow for timely implementation of prevention and control measures. To appropriately implement infection control measures, an important aspect of facility- based surveillance is the patient assessment performed by health care workers to identify risk factors for VRE colonization and symptoms of infection.

As recommended in the 1998 SC DHEC Guidelines for Prevention and Control of Antibiotic Resistant Organisms in Health Care Settings, each health care facility should conduct surveillance for VRE, identify outbreaks and implement control measures, and monitor antibiograms for the isolates from their facility. Active surveillance culture programs and strict attention to infection control precautions have been shown to reduce nosocomial VRE transmission.

Currently DHEC is working with some hospital and reference labs to send electronic laboratory reports to DHEC. These labs participating in the electronic lab reporting projects should continue to submit VRE data. However, it is no longer necessary to complete the disease report cards for VRE. Over the next year or two, as more laboratories begin to send data electronically, lab reporting will be an important part of public health surveillance for antibiotic resistance. This will reduce the burden on hospital personnel to complete the written disease reports.

Streptococcus pneumoniae, invasive disease (including resistance patterns), and the urgently reportable Vancomycin resistant *Staphylococcus aureus* should continue to be reported as individual cases from hospitals, laboratories, and physicians.

2006 SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL DISEASE REPORTING CARD

Disease reporting is required by SC Code of Laws Section 44-29-10, Regulation 61-20, 44-1-110, and 44-1-140. **See other side for list of reportable diseases.**

HIPAA: Federal HIPAA legislation allows disclosure of protected health information, without consent of the individual, to public health authorities to collect and receive such information for the purpose of preventing or controlling disease. (HIPAA 45 CFR §164.512)

Patient Name (Last) (First) (Middle)	**Date of Birth** Month / Day / Year	**Race** ☐ White ☐ Black ☐ Asian ☐ Am.Ind. ☐ Unk.	**Ethnicity** ☐ Hisp. ☐ Unk. ☐ Non-Hispanic	**Sex** ☐ Male ☐ Female ☐ Not Stated	**Patient Status** ☐ In Daycare ☐ Pregnant ☐ Food Handler
Patient Address / City and Zip Code		**County**		**Patient ID or SSN**	**Telephone Numbers**
Disease (Include stage, if appropriate)	**Criteria for Diagnosis** ☐ Clinical ☐ Laboratory ☐ Both	**Date of Onset:** ☐ Symptoms _____ ☐ Diagnosis _____	**Specific Laboratory Results**		**Specimen Site** / **Collection Date**

Hepatitis A Serology Results
Hepatitis A antibody (Acute IgM anti-HAV) ☐ Pos ☐ Neg ☐ Unk

Hepatitis C Serology Results
Hepatitis C – EIA ☐ Pos ☐ Neg ☐ Unk s/co ratio:_____
Hepatitis C – RIBA ☐ Pos ☐ Neg ☐ Unk
Hepatitis C – NAT ☐ Pos ☐ Neg ☐ Unk
Hepatitis C – PCR ☐ Pos ☐ Neg ☐ Unk
Hepatitis C – ViralLoad_____

Hepatitis B Serology Results

	Pos	Neg	Unk
Hepatitis B surface Antigen (HBsAg)	☐	☐	☐
Hepatitis B core Antibody IgM (HBcAb - IgM)	☐	☐	☐
Hepatitis B core Antibody Total (HBcAb)	☐	☐	☐
Hepatitis B surface Antibody (HBsAb)	☐	☐	☐
Hepatitis B e Antigen (HBeAg)	☐	☐	☐

Hepatitis Diagnosis
Hepatitis A ☐ Acute
Hepatitis B ☐ Acute ☐ Chronic
Hepatitis C ☐ Acute ☐ Chronic
Hepatitis Other_____

Hepatitis Clinical Information
Pregnant: ☐ Yes ☐ No Jaundice: ☐ Yes ☐ No
Elevated ALT/AST: ☐ Yes ☐ No

For STD Reporting
Pregnant: ☐ Yes ☐ No
Treated: ☐ Yes ☐ No
Rx_____
Treatment planned: ☐ Yes ☐ No
Treatment unknown: ☐ Yes ☐ No

Responsible Physician & Phone #	**Reporting Lab/Facility, Person, & Phone #**	**Date Reported to Health Department**	**Mail or Call Reports To:**

For daytime & after-hours phone numbers: www.scdhec.gov/health/disease/docs/reportable_conditions.pdf
For after-hours reporting of immediately reportable conditions, call the statewide emergency pager: 1-888-847-0902.

☐ **Send More Cards To: (Address)**

For DHEC Use Only (Initial & Date) County Review Date State Review Date C P S N
DHEC 1129 (01/2006)

Reporting required by attending physician/designee and laboratory except where (L) reporting is indicated.

Report IMMEDIATELY by Phone

- ☣ **ANY outbreak or unusual disease or cluster of cases to include a potential biological, chemical, or terrorist event (1)**
- Animal (mammal) bites
- ☣ Anthrax (7)
- ☣ Botulism
- ☣ Foodborne outbreak – unusual cluster
- *Haemophilus influenzae* type b, invasive disease (4) (7)
- Measles (rubeola)
- Meningococcal disease (7)
- ☣ Plague (7)
- Poliomyelitis
- SARS, Severe Acute Respiratory Syndrome (by current CDC case definition) (7)
- ☣ Smallpox
- ☣ Viral Hemorrhagic Fever

Urgently Reportable Within 24 Hours By Phone

- Arboviral Neuroinvasive Disease (acute infection, including acute flaccid paralysis, atypical Guillain-Barre Syndrome): Eastern Equine Encephalitis (EEE), Lacrosse (LAC), St. Louis (SLE), West Nile Virus (WNV) (7)
- ☣ Brucellosis (7)
- Cholera (*Vibrio cholerae)* type O1 and non-O1 (7)
- Diphtheria (7)
- Enterohemorrhagic E. Coli (includes O157:H7) (7)
- ☣ Glanders (7)
- Hantavirus
- Hemolytic uremic syndrome (HUS)
- Hepatitis A, acute (IgM Ab+ only)
- Hepatitis B, acute (IgM core + only)
- ☣ Melioidosis (*Burkholderia pseudomallei*) (7)
- Pertussis
- ☣ Q fever
- Rabies (human)
- Rubella (includes congenital)
- *Staphylococcus aureus*, vancomycin-resistant (VRSA/VISA)
- Syphilis, primary or secondary (lesion or rash)
- Syphilis, congenital
- ☣ Toxins (i.e., Ricin, *C. Perfringens,* Staph enterotoxin)
- Trichinosis
- Tuberculosis (7)
- ☣ Tularemia
- Typhoid fever (*Salmonella typhi*)(7)
- ☣ Typhus (scrub) fever

Report Within 7 Days

- AIDS (2)
- Campylobacter enteritis
- CD4 T-lymphocyte count – all results (L) (2)
- Chancroid
- Chlamydia trachomatis, genital site (L)
- Creutzfeldt-Jakob Disease (Age <55 years)
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- Ehrlichiosis
- Giardiasis
- Gonorrhea
- *Haemophilus influenzae,* non-type b invasive disease (4)(7)
- Hepatitis B, chronic
- Hepatitis B Surface Antigen+ (HbsAg+) with each pregnancy
- Hepatitis C, D, E
- HIV-1 or HIV-2 infection (2)
- HIV quantification/viral load - all results(L) (2)
- Influenza, positive rapid flu test (report # of positive results weekly)
- Influenza, positive virus culture isolates (L)
- Influenza, pediatric deaths - age < 17 years
- Kawasaki disease
- Lead poisoning (5)
- Lead tests, all (6) (L, includes office tests)
- Legionellosis
- Leprosy
- Leptospirosis
- Listeriosis (7)
- Lyme disease
- Lymphogranuloma venereum
- Malaria
- Meningitis, aseptic (8)
- Mumps
- Pesticide poisoning
- ☣ Psittacosis
- Rocky Mountain Spotted Fever
- Salmonellosis (7)
- Shigellosis (7)
- Streptococcus group A, invasive disease (4)
- Streptococcus group B, age < 90 days
- *Streptococcus pneumoniae*, invasive, (4) (include antibiotic resistance patterns) (3)
- Syphilis, latent or tertiary
- Syphilis, positive serologic test
- Tetanus
- Toxic Shock (Staphylococcal or Streptococcal)
- Varicella
- Varicella death
- Vibrio infections (non-cholera)
- Yellow Fever
- Yersiniosis (L)

☣ Potential agent of bioterrorism (L) Only Labs required to report For notes 1–8, see complete list of reportable diseases at: www.scdhec.gov/health/disease/docs/reportable_conditions.pdf

S.C. 2006 List of Reportable Conditions

Attention: Health Care Facilities, Physicians, and Laboratories

South Carolina Law requires reporting of diseases and conditions on this list to your local public health department.
(State Law # 44-29-10, Regulation # 61-20, State Laws #44-1-110 and 44-1-140.)

HIPAA: Federal HIPAA legislation allows disclosure of protected health information, without consent of the individual, to public health authorities to collect and receive such information for the purpose of preventing or controlling disease. (HIPAA 45 CFR §164.512)

REPORT IMMEDIATELY by Phone (Confirmed and Suspected Cases)

Any outbreak, unusual disease, or cluster of cases to include a potential biological, chemical, or terrorist event. (1)
- Animal (mammal) bites
- ☣ Anthrax (7)
- ☣ Botulism
- ☣ Food borne outbreak – unusual cluster
- *Haemophilus influenzae* type b, invasive disease (4) (7)
- Measles (rubeola)
- Meningococcal disease (7)
- ☣ Plague (7)
- Poliomyelitis
- SARS – Severe Acute Respiratory Syndrome (7) (by current CDC case definition)
- ☣ Smallpox
- ☣ Viral Hemorrhagic Fever

Urgently Reportable within 24 Hours by Phone

- Arboviral Neuroinvasive Disease (acute infection, including acute flaccid paralysis, atypical Guillain-Barre Syndrome): Eastern Equine (EEE), LaCrosse (LAC), St. Louis (SLE), West Nile Virus (WNV) (7)
- ☣ Brucellosis (7)
- Cholera (*Vibrio cholerae* type O1 and non-O1) (7)
- Diphtheria (7)
- Enterohemorrhagic E. Coli (includes O157:H7) (7)
- ☣ Glanders (7)
- Hantavirus
- Hemolytic uremic syndrome (HUS)
- Hepatitis A, acute (IgM Ab + only)
- Hepatitis B, acute (IgM core Ab + only)
- ☣ Melioidosis *(Burkholderia pseudomallei)* (7)
- Pertussis
- ☣ Q fever
- Rabies (human)
- Rubella (includes congenital)
- *Staphylococcus aureus*, vancomycin-resistant (VRSA/VISA)
- Syphilis, primary or secondary (lesion or rash)
- Syphilis, congenital
- ☣ Toxins (i.e., Ricin, *C. perfringens, S*taph enterotoxin)
- Trichinosis
- Tuberculosis (7)
- ☣ Tularemia
- Typhoid fever *(Salmonella typhi)* (7)
- ☣ Typhus (scrub) fever

☣ Potential agent of bioterrorism ☣

Report within 7 Days

- AIDS (2)
- Campylobacter enteritis
- CD4 T-lymphocyte count – all results (L) (2)
- Chancroid
- Chlamydia trachomatis, genital site (L)
- Creutzfeldt - Jakob Disease (Age < 55 years)
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- Ehrlichiosis
- Giardiasis
- Gonorrhea
- *Haemophilius influenzae*, non-type b invasive disease (4) (7)
- Hepatitis B, chronic
- Hepatitis B Surface Antigen + (HBsAg +) with each pregnancy
- Hepatitis C, D, E
- HIV-1 or HIV-2 infection (2)
- HIV quantification / viral load - all results (L) (2)
- Influenza, positive rapid flu test (#)
- Influenza, positive virus culture isolates (L)
- Influenza, pediatric deaths - age < 17 years
- Kawasaki disease
- Lead poisoning (5)
- Lead tests, all (6) (L, includes office tests)
- Legionellosis
- Leprosy
- Leptospirosis
- Listeriosis (7)
- Lyme disease
- Lymphogranuloma venereum
- Malaria
- Meningitis, aseptic (8)
- Mumps
- Pesticide poisoning
- ☣ Psittacosis
- Rocky Mountain Spotted Fever
- Salmonellosis (7)
- Shigellosis (7)
- Streptococcus group A, invasive disease (4)
- Streptococcus group B, age < 90 days
- *Streptococcus pneumoniae*, invasive, (4) (include antibiotic resistance patterns) (3)
- Syphilis, latent or tertiary
- Syphilis, positive serologic test
- Tetanus
- Toxic Shock (Staphylococcal or Streptococcal)
- Varicella
- Varicella death
- Vibrio infections (non-cholera)
- Yellow Fever
- Yersiniosis (L)

(L) Only Labs required to report.
(#) Report only total number of positive results; individual case reporting is not necessary

1. Outbreak: An excess number of cases or syndromes over the expected occurrence of disease within a geographic area or population group.
2. Report HIV or AIDS when serum, urine, or oral fluid specimen is positive by: (a) screening test (e.g., EIA antibody) ***or*** (b) confirmatory test (e.g., Western blot) ***or*** (c) an HIV detection test (e.g., PCR nucleic acid test, including viral load), ***or*** (d) clinical diagnosis of a case of HIV or AIDS. All reactive rapid HIV test results must be reported to DHEC. However, if a confirmation test is performed within 14 days and is negative, reactive EIAs alone should not be reported. All HIV viral load and CD4 test results must be reported by laboratories regardless of results. For reporting procedure, see "How to Report."
3. Antibiotic resistant organisms: resistant pneumococcus: MIC ≥ 2µg/ml of penicillin G (or Oxacillin disc zone ≤ 19mm) or resistance to any single drug accepted as effective treatment. The definition of resistance may differ between laboratories by test methods used to determine susceptibility. Reports should specify the site from which the isolate was obtained and the drug susceptibility profile.
4. Invasive disease = isolated from normally sterile site: blood; bone; CSF; joint; pericardial, peritoneal or pleural fluid; necrotizing fasciitis; and cellulitis only if isolate is from a tissue biopsy. Always specify site of isolate.
5. Physicians should report serum lead level ≥10 µg/dL for children under 6 years of age and ≥ 25 µg/dL for persons 6 years or older.
6. Labs must report results of all lead tests performed. This includes lab tests performed in physician offices.
7. Labs should submit these isolates and positive serologies to the DHEC Bureau of Laboratories for confirmatory testing, serotyping, serogrouping, or genotyping.
8. Acute meningeal symptoms, fever, CSF pleocytosis, sterile culture. Consult SC DHEC in outbreaks to submit specimens to lab for virus identification.

S.C. 2006 List of Reportable Conditions

South Carolina Department of Health and Environmental Control

How to Report

Submit reports by one of the following methods:

1. For **immediately** and **urgently** reportable conditions (M-F, 9-5), call your regional public health office. See list below.
2. For **immediately** reportable conditions: nights, weekends, and holidays, call the statewide DHEC emergency phone number: 1-888-847-0902.
3. For routine reports, call your regional public health office or complete the DHEC 1129 Disease Reporting Card and mail in an envelope marked confidential to your regional public health office. (See list below.)
4. For HIV and AIDS, report these conditions by calling 1-800-277-0873 or (803) 898-0758, or by submitting a DHEC 1129 Disease Reporting Card or appropriate CDC Case Report Form to: STD/HIV Surveillance Division, Mills/Jarrett Complex, Box 101106, Columbia, SC 29211.

What to Report

- Patient's name
- Patient's complete address, phone, date of birth, race, sex, county, Social Security Number
- Physician's name and phone
- Name, institution, and phone number of person reporting
- Disease or condition
- Date of onset of disease and date of report
- Lab results, specimen site, collection date
- Status: if pregnant, in daycare, or a food-handler

DHEC may request additional clinical information on a separate Case Report Form.

Regional Public Health Offices

Mail or call reports to the Epidemiology Office in each Public Health Region.

Region 1

(Anderson, Oconee)
220 McGee Road
Anderson, SC 29625
Phone: (864) 231-1966
Fax: (864) 260-5623
Nights / Weekends: 1-866-298-4442

(Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda)
P.O. Box 3227
1736 S. Main Street
Greenwood, SC 29646
Phone: 1-888-218-5475
Fax: (864) 942-3690
Nights / Weekends: 1-800-420-1915

Region 2

(Greenville, Pickens)
P.O. Box 2507
200 University Ridge
Greenville, SC 29602-2507
Phone: (864) 282-4139
Fax: (864) 282-4373
Nights / Weekends: (864) 460-5355 or 1-800-993-1186

(Cherokee, Spartanburg, Union)
P.O. Box 4217
151 E. Wood Street
Spartanburg, SC 29305-4217
Phone: (864) 596-2227 ext. 210
Fax: (864) 596-3443
Nights / Weekends: 1-800-993-1186

Region 3

(Chester, Lancaster, York)
P.O. Box 817
1833 Pageland Highway
Lancaster, SC 29721
Phone: (803) 286-9948
Fax: (803) 286-5418
Nights / Weekends: 1-866-867-3886 or 1-888-739-0748

Region 3 cont.

(Fairfield, Lexington, Newberry, Richland)
2000 Hampton Street
Columbia, SC 29204
Phone: (803) 576-2749
Fax: (803) 576-2993
Nights / Weekends: (803) 304-4252

Region 4

(Clarendon, Kershaw, Lee, Sumter)
P.O. Box 1628
105 North Magnolia Street
Sumter, SC 29150
Phone: (803) 773-5511
Fax: (803) 773-6366
Nights / Weekends: 1-877-831-4647

(Chesterfield, Darlington, Dillon, Florence, Marlboro, Marion)
145 E. Cheves Street
Florence, SC 29506
Phone: (843) 661-4830
Fax: (843) 661-4859
Nights / Weekends: (843) 660-8145

Region 5

(Bamberg, Calhoun, Orangeburg)
P.O. Box 1126
1550 Carolina Avenue
Orangeburg, SC 29116
Phone: (803) 533-7199
Fax: (803) 536-9118
Nights / Weekends: (803) 954-8513

(Aiken, Allendale, Barnwell)
1680 Richland Avenue, W. Suite 40
Aiken, SC 29801
Phone: (803) 642-1618
Fax: (803) 643-8386
Nights / Weekends: (803) 827-8668 or 1-800-614-1519

Region 6

(Georgetown, Horry, Williamsburg)
2830 Oak Street
Conway, SC 29526-4560
Phone: (843) 365-3126
Fax: (843) 365-3153
Nights / Weekends: (843) 381-6710

Region 7

(Berkeley, Charleston, Dorchester)
4050 Bridge View Drive, Suite 600
N. Charleston, SC 29405
Phone: (843) 746-3806
Fax: (843) 746-3851
Nights / Weekends: (843) 219-8470

Region 8

(Beaufort, Colleton, Hampton, Jasper)
219 S. Lemacks Street
Walterboro, SC 29488
Phone: (843) 525-7603
Fax: (843) 549-6845
Nights / Weekends: 1-800-614-4698

DHEC Bureau of Disease Control

Acute Disease Epidemiology Division
1751 Calhoun Street
Box 101106
Columbia, SC
Phone: (803) 898-0861
Fax: (803) 898-0897
Nights / Weekends: 1-888-847-0902

D H E C
PROMOTE PROTECT PROSPER

www.scdhec.gov

Promoting and protecting the health of the public and the environment

CR-005869 11/05

"Get the Point" Program

Margie Davis
Infectious and Radioactive Waste Section
Bureau of Land and Waste Management

The South Carolina Department of Health and Environmental Control would like to remind the health care community of the existence and benefits of the "Get the Point" program. This program is designed to educate individuals in the community who need to discard used needles/contaminated sharps (ie, diabetics).

The "Get The Point" program is an inexpensive way to safely dispose of home-generated needles and sharps. Home-generated sharps are discarded in a 2-liter soda bottle. Once the bottle is two-thirds full, it is tightly capped, sealed and labeled with a DO NOT RECYCLE sticker and thrown away in household trash. Studies indicate that the recommended two-liter soda bottle is able to withstand more stresses around the home and at the landfill. We are promoting this program to district nurse offices, public health department clinics, program nurse managers, home health services, doctor's offices and hospitals within the State.

Brochures explaining the program and stickers to distribute in health care settings may be obtained by contacting Margie Davis at davisml@dhecsc.gov. Below is a Web site for the program. We will also be happy to visit areas with brochures and stickers and demonstrate this important community program.

DHEC is also committed to assisting the community with questions involving accidental needle-sticks and the disposal of sharps. Needle-stick inquiries are referred to DHEC health professionals and staff who can advise a person on the best course of action until the person is able to see their health care provider.

http://www.scdhec.net/lwm/html/infect.html

Neuroinvasive Disease - A New Term For Arboviral Encephalitides

Lena M. Bretous, MD, MPH
Medical Epidemiologist

The revised terminology concerning arboviral meningitis and encephalitis follows the new CDC terminology for more severe arboviral disease. In recent years, the terms encephalitis, meningitis, or meningoencephalitis have been used interchangeably. For better quality assurance of data collection and recording of clinical syndromes associated with West Nile virus disease, the term neuroinvasive has replaced terms such as encephalitis or meningitis. The term neuroinvasive is used as part of the CDC case definition for all arboviral diseases formerly known as encephalitides.

Ask Epi

Post-exposure Prophylaxis after Pre-exposure Prophylaxis?

Eric Brenner, MD
Medical Epidemiologist

At the DHEC Bureau of Disease Control we regularly field questions from providers rconcerning infectious diseases, public health, and epidemiology. We invite our readers to submit questions to AskEpi@sc.dhec.gov. In recent issues this column has discussed the problem of false positive IgM tests and issues relating to BCG vaccine efficacy and its impact on the interpretation of subsequent tuberculin skin tests. Here, we address a question relating to post-exposure prophylaxis of Hepatitis A (and other infectious diseases).

Question: In our practice we recently saw a child from out-of-state who had been a household contact to a recently diagnosed case of hepatitis A. Since we had seen the child within14 days following her exposure to the source case, she seemed to be a candidate to receive Immune Globulin (IG) as post-exposure prophylaxis. However, the child's vaccine record showed she had previously received hepatitis A vaccine. The question, therefore, was whether IG was still indicated in this situation.

Ask Epi's Answer: Though this question relates to a particular situation involving hepatitis A, it also provides a good opportunity to consider the more general question about when, whether, and why pre-exposure prophylaxis (PrEP) [usually a vaccine] may, or may not, modify otherwise standard indications for post-exposure prophylaxis (PoEP). We will address this more general question through several hypothetical case scenarios:

Scenario 1 - Pertussis: Two siblings, a20 month-old and a 2 month-old have been exposed to a case of pertussis. The 20-month-old has received four doses of DTP; the 2-month old has yet to receive a single dose. Standard guidelines[1] recommend that the children's immunization histories not be taken into account and that both children receive identical courses of PoEP with erythromycin (or with a newer macrolide).

Scenario 2 - Rabies: A forestry field worker has previously received PrEP rabies vaccine because of potential occupational risk. While walking in the woods, he is bitten

(Continued on Page 8)

by a raccoon. the racoon tests postive for rabies. Although rabies PoEP normally calls for administration of Rabies Immune Globulin (RIG) and five doses of rabies vaccine administered over a 28-day period, recommendations for this previously vaccinated patient are that he need not receive RIG and needs to receive only two doses of rabies vaccine, administered over a 4-day period.[2]

Scenario 3 - Hepatitis A: This scenario is the one that described in the question addressed to "Ask Epi" above. Here standard guidelines state that: “Persons who have been recently exposed to HAV and who have not previously been administered hepatitis A vaccine should be administered a single IM dose of IG (0.02 mL/kg) as soon as possible, but not >2 weeks after the last exposure. Persons who have been administered one dose of hepatitis A vaccine at least 1 month before exposure to HAV do not need IG".[3]

Comment: These scenarios illustrate that the details and inter-relationships between PrEP and PoEP are complex and vary from one infectious disease to another. Thus, following PrEP and then an “exposure”, PoEP may:

(a) remain necessary without modification of guidelines (e.g. pertussis)
(b) remain necessary but with modified details (e.g. rabies)
(c) not be necessary and may be dispensed with altogether (hepatitis A)

Further, for some diseases, guidelines regarding PoEP are so complex, with the best course of action dependent on many variables, that recommendations cannot readily be presented in a single sentence or two; rather, they must be presented in a structured table.

A familiar example is the table summarizing the approach to tetanus PoEP where the need to administer Tetanus Immune Globulin (TIG) and/or a booster dose of Td depends on: (a) the number of doses of TT/Td/DPT previously received, (b) the number of years since the last dose was administered, and (c) the nature and extent of the wound.[1]

Likewise, the approach to needle stick Hepatitis B PoEP is summarized in an even more complex table which takes into account the vaccination and antibody response status of the exposed person and what is known about the HBsAg status of the source.[4] In the case of HIV the issues surrounding PoEP following occupational exposures (e.g. needle sticks) are so complex that even in the absence of any recommendations for PrEP a dozen pages or more are required to present the latest recommendations.[5]

In a few instances specific guidance on the relationship between PoEP and PrEP are lacking. For example, following the January 2005 licensure of the new tetravalent meningococcal polysaccharide-protein conjugate vaccine, the CDC published updated recommendations regarding the prevention and control of meningococcal disease.[6]
However, in the section devoted to Antimicrobial Chemoprophylaxis, no mention at all is made of whether or how standard recommendations for PoEP antibiotic chemoprophylaxis ought to be modified for persons who have received the vaccine. Thus, pending future guidance, management of a teenager who had received the vaccine but was later found to be a close (e.g. household) contact to a case of meningococcal meningitis would have to depend on “expert opinion” rather than on published guidelines.

This last example notwithstanding, current versions of standard guidelines (such as those from the US Centers for Disease Control or the American Academy of Pediatrics) include considerably more detailed guidance than was available in earlier versions. Thus, the majority of situations commonly encountered in clinical practice are now explicitly addressed.

Local public health departments as well as DHEC’s Division of Acute Disease Epidemiology (Tel: 803-898-0861) are available for consultation regarding issues of post-exposure prophylaxis for individuals or groups exposed to communicable diseases.

References:

1. American Academy of Pediatrics. Red Book - Report of the Committee on Infectious Diseases. 26th edition, 2003. (for pertussis: p. 475; for Tetanus: table 3.61, p. 614).

2. CDC. Human Rabies Prevention — United States, 1999. MMWR January 8, 1999 / Vol. 48 / No. RR-1.

3. CDC. Prevention of Hepatitis A Through Active or Passive Immunization. MMWR October 1, 1999 / Vol. 48 / No. RR-12.

4. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. MMWR June 29, 2001 / Vol. 50 / No. RR-11.

5. CDC. Update U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis. MMWR September 30, 2005 / Vol 54 / No. RR-9.

6. CDC. Prevention and Control of Meningococcal Disease. MMWR May 27, 2005 / Vol. 54 / No. RR-7.

Year-to-Date Summary of Reportable Conditions*
September 28, 2005 - December 2, 2005

Condition	Confirmed	Probable	Total
Aseptic meningitis	75	24	99
Bacterial meningitis- other	2		2
Brucellosis	1		1
Campylobacteriosis	193	2	195
Cryptosporidiosis	21	1	22
Cyclosporiasis	3		3
Dengue Fever	1		1
Ehrlichiosis- human granulocytic	6	3	9
Ehrlichiosis- human monocytic	1	3	4
Ehrlichiosis- human- other&unspec		4	4
Encephalitis- Eastern equine	1		1
Encephalitis- West Nile	3		3
Enterohem. E.coli O157:H7	8		8
Enterohem.E.coli shigatox+- ?serogrp	2	1	3
Enterohem.E.coli- shigatox+- non-O157	1		1
Giardiasis	97	2	99
Group A Streptococcus- invasive	31		31
Group B Streptococcus- invasive	18		18
Haemophilus influenzae- invasive	31		31
Hemolytic uremic synd- postdiarrheal	1		1
Hepatitis A- acute	35	4	39
Hepatitis B- acute	126	24	150
Hepatitis B virus infection- chronic	522	80	602
Hepatitis C- acute	1	3	4
Hepatitis C Virus Infection- chronic or resolved	2184	2223	4407
HTLV-I infection	1		1
HTLV-II infection	2		2
Influenza- human isolates	51		51
Influenza- Rapid Test	2	1	3
Influenza-like Illness	1		1
Kawasaki disease	2	1	3
Legionellosis	14	2	16
Listeriosis	13		13
Lyme disease	15	7	22
Malaria	9		9
Mumps	1		1
Neisseria meningitidis- invasive (Mening. disease)	14	1	15
Pertussis	337	36	373
Q fever		1	1
Rocky Mountain spotted fever	21	55	76
S. aureus- coag+- meth- or oxi- resistant (MRSA)	3		3
Salmonellosis	1113	246	1359
Scombroid fish poisoning	2		2
Shigellosis	92	4	96
Strep pneumoniae- invasive	153	2	155
Streptococcal disease- invasive- other	20		20
Vancomycin-Resistant Enterococcus	1353	5	1358
* Varicella (Chickenpox)	194	328	522
Vibrio spp.- non-toxigenic- other or unspecified	5		5
West Nile Fever	2		2
Yersiniosis	2		2

* This report does not include reportable STD conditions.

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SC DHEC
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Columbia, SC 29201

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FOR DISEASE REPORTING

For immediately reportable conditions, call your local county health department or, for after-hours, call 1-888-847-0902. Routine reports may be phoned in to your local health department or mailed on a completed DHEC DISEASE REPORTING CARD (DHEC 1129) .

Local county health department numbers are listed on the Official List of Reportable Conditions. For a copy of the current Official List of Reportable Conditions, call 803-898-0861 or visit www.scdhec.gov/health/disease/index.htm

THE EPI NOTES NEWSLETTER IS NOW AVAILABLE ON LINE AT
www.scdhec.gov/health/disease/index.htm

Bureau of Disease Control
J. Gibson, MD, MPH, Director
803-898-0861

Bureau of Disease Control Divisions
Division of Acute Disease Epidemiology
803-898-0861
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South Carolina Department of Health and Environmental Control

Editorial Staff
Editors: Libby C. Greene, MSN, APRN, BC
Claire Youngblood, MA
Design and Layout: Gloria A. McCurry